HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care

Please answer each question. Circle Yes or No where applicable. Example: Are you alive ..... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____ Name Of Physician _____ Phone _____
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have your even been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any medicine ☐ Yes ☐ No or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If so, what? _____ What dosage? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; ☐ Latex; ☐ Other .....
   ☐ Other If Other, what drugs? _____
9. Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Heart Murmur	☐	☐	Mental Disorder	☐	☐	AIDS Related Complex	☐	☐	Chemotherapy	☐	☐
Herpes	☐	☐	Bruise Easily	☐	☐	Rheumatic Fever	☐	☐	Pain in Jaw Joint	☐	☐	(Cancer, Leukemia)		
Stroke	☐	☐	Head Injuries	☐	☐	Thyroid Disease	☐	☐	Respiratory Disease	☐	☐	Radiation Treatment	☐	☐
Ulcers	☐	☐	Heart Failure	☐	☐	Cerebral Palsy	☐	☐	Sickle Cell Disease	☐	☐	Hepatitis or Jaundice	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Blood Transfusion	☐	☐	Tuberculosis (T.B.)	☐	☐	Venereal Disease	☐	☐
Glaucoma	☐	☐	Scarlet Fever	☐	☐	Joint Replacement.	☐	☐	Epilepsy or Seizure	☐	☐	(Syphilis, Gonorrhea)		
Arthritis	☐	☐	Chicken Pox	☐	☐	Nervous Disorder	☐	☐	Artificial Prosthesis	☐	☐	Acquired Immune		
Emphysema	☐	☐	Sinus Trouble	☐	☐	Tumors or Growths	☐	☐	Psychiatric Treatment	☐	☐	Def. Synd. (AIDS)	☐	☐
Hay Fever	☐	☐	Blood Disease	☐	☐	Allergies or Hives	☐	☐	Congenital Heart Lesions	☐	☐	HIV Positive	☐	☐
Tonsilitis	☐	☐	Drug Addiction	☐	☐	Cortisone Medicine	☐	☐	Difficulty in Swallowing	☐	☐	Y N Pain in Jaw Joints		
Cold Sores	☐	☐	Kidney Disease	☐	☐	Excess. Bleeding	☐	☐	Heart Ailmt. or Attack	☐	☐	Y N TMJ (Temporomandibular Joint) Disorder		
Hemophilia	☐	☐	Stomach Ulcers	☐	☐	Asthma	☐	☐	X-Ray or Cobalt Treatment	☐	☐			
Rheumatism	☐	☐	Agina Pectoris	☐	☐	High Blood Pressure	☐	☐	Fainting Spells or Seizures	☐	☐			

10. Do you wear a cardiac pacemaker, or have you had heart surgery ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
12. (Women) Are you pregnant? If so how many months _____ ..... Yes No
13. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
14. (Women) Do you take birth control pills? ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last dental treatment? _____
6. Does dental treatment make you nervous ..... Yes No
   If Yes, Check ✓: ☐ Slightly ☐ Moderately ☐ Extremely
7. Would you desire to be pre-sedated? ..... Yes No

Do you smoke? If yes, how much? ☐ Cigarettes ☐ Cigars ☐ Packs per day ..... Yes No

Have you ever taken the drugs "Phen-Phen" or "Redux"? ..... Yes No

Date _____ **Signature** _____

Year 2

Changes in Health _____

Date _____ **Signature** _____

Year 3

Changes in Health _____

Date _____ **Signature** _____

Health Questionnaire MUST be updated every year!

REVIEWED BY	DO NOT WRITE IN THIS SPACE			
		Year 1	Year 2	Year 3
YEAR 1	Date			
	BP	/	/	/
YEAR 2	Pulse			
	Temp			
YEAR 3	By			

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof

Signed: _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____